Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families

(CFDA# 93.110AF)

Grant Application Guidance
March 2000

NOTE: This document is not a complete kit. The necessary forms are enclosed with this document. Read this entire document carefully before starting to prepare an application.

Application Due Date: May 16, 2000
Anticipated Date of Award: July 1, 2000

Health Resources and Services Administration
and the
Substance Abuse and Mental Health Services Administration
United States Public Health Service
United States Department of Health and Human Services

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CHAPTER 1 INTRODUCTION

1.1 Overview of the Maternal and Child Health Bureau=s Mission

The Maternal and Child Health Bureau (MCHB) responds to matters affecting the health and well-being of infants, children, adolescents, mothers and families. The Bureau provides national leadership by working with States, communities, public-private partners and families to strengthen the maternal and child health (MCH) infrastructure, assure the availability and use of medical homes and build knowledge and human resources required to strengthen and maintain the health, safety and well-being of the Nation=s MCH population. The MCH population consists of all pregnant women, infants, children, adolescents and their families, including women of reproductive age, fathers, and children with special health care needs (CSHCN).

MCH issues of concern include, but are not limited to: Services for low-income and minority women and children; immunizations; health and safety in child care and foster care; emergency medical services for children; violence and injury prevention; school health; environmental health including lead poisoning prevention; adolescent health, including mental health and suicide prevention; traumatic brain injury; family health; and a variety of regional and/or national projects.

All MCHB-supported services or projects have as their goals the development of: 1) more effective ways to coordinate and deliver new and existing systems of care; 2) leadership for maternal and child health programs throughout the United States; 3) innovative outreach techniques to identify and deliver appropriate care and preventive education to at-risk populations; 4) a body of knowledge that can be tapped by any part of the MCH community; and 5) significant and fundamental improvement in the lives and health of our Nation=s mothers and their children.

The MCHB relies heavily on effective communication and interactive relationships with key organizations to: Support health and health-related programs and services; encourage efficient use of resources; strengthen and enhance research to broaden the knowledge base for MCH programs; train individuals within the various health professions to provide leadership in the provision of comprehensive health care to mothers and children; and enhance the skills of State and local MCH personnel.

1.2 Program Background

1.2.1 Overview of the Functions of the Office of Adolescent Health and of the Substance Abuse and Mental Health Services Administration

The Office of Adolescent Health (OAH) was established in 1995 by Congressional mandate and delegated to the Health Resources and Services Administration (HRSA), where it is placed within the MCHB. Part of the OAH=s charge is to coordinate and provide mechanisms for activities

that promote the comprehensive health of adolescents. The OAH includes children and families in its program activities, especially as part of its efforts to ensure a healthy developmental progression from childhood to adulthood. In addition, the OAH focuses on youthful populations who face additional challenges to healthy outcomes and a secure adult future because of such social and environmental factors as poverty, minority ethnic status, and living in geographic areas with scarce health resources.

In 1992 Congress created the Substance Abuse and Mental Health Services Administration (SAMHSA) as the lead agency for support of knowledge development, dissemination and application in the areas of mental health, substance abuse prevention and substance abuse treatment services. SAMHSA is composed of the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP).

1.2.2 Rationale for Initiative

It is estimated that twenty percent or 11 million children and adolescents in the United States have a diagnosable behavioral health problem. Important examples include depression, anxiety disorders, attention deficit disorders, conduct disorders, and substance use disorders. Almost 70 percent of these children and adolescents do not receive the services necessary to address these problems. For the children and adolescents who do receive behavioral health services, care is often fragmented with minimal coordination of effort between the primary care and specialty mental health providers involved in the management of their problems. The rapid growth of the managed care sector over the past decade has had a dramatic impact on the delivery of behavioral health care services; primarily, it has Acarved out@ behavioral health services from general health care, which has further compounded the problem of coordinated access to primary health and behavioral health care services.

Primary health care practitioners can play a critical role in identifying children and adolescents with behavioral problems and in participating in the treatment of these youngsters, either by providing treatment themselves or co-managing treatment with mental health or substance abuse prevention/treatment specialists and collaborating with other relevant services in the community. Conversely, behavioral health specialists can play an important role in the physical health care of their patients by ensuring that they receive timely and appropriate attention to their general health care and medical needs. Patients with mental health problems need consistent care for their non-psychiatric problems. In addition, some medical disorders, even in children and adolescents, present as mental problems. The affiliated behaviors of many patients with mental health and substance use problems heighten their risks for trauma and certain medical diseases.

An important contemporary approach to increasing children=s and adolescents= access to

behavioral health services and to enhancing the overall quality of their comprehensive health care is to integrate mental health and substance abuse prevention and treatment services into the primary care setting. In integrated systems of care, patients= diagnoses are less likely to be dichotomized into biological and psychosocial categories; there is recognition that many diagnoses are simultaneously biological and psychological.

There are several cogent reasons to integrate services: 1) The large majority of children and adolescents have access to and utilize primary health care services. Patients with mental health and substance abuse problems frequently manifest their emotional distress through biological and behavioral symptoms, and present to a primary care setting for assistance rather than to a traditional mental health setting. Patients with psychological responses to life cycle changes and environmental stressors are also more likely to consult their primary care clinician rather than a mental health professional. 2) Existing mental health problems and dangerous environmental conditions, such as chronic physical danger and violence, can be identified and intervened with at an earlier time, which may prevent more serious ramifications and major trauma, both physical and psychological. 3) Primary care clinicians are not able to provide appropriate care to the full range of psychological and psychiatric problems, and referral to isolated mental health providers is frequently not successful. Either patients do not complete the referral process or they feel stigmatized and abandoned by the physical health care system, and are not able to establish a therapeutic relationship with the mental health professional. 4) The large majority of traditional psychiatric diagnoses are cared for in out-patient settings. 5) Compared to traditional primary care and mental health settings, integrated settings increase the satisfaction levels of both clinicians and patients. 6) The costs of providing care in integrated settings are well controlled; they are no more expensive than the costs of traditional care, and frequently are less costly.

At this time, however, relatively few models of integrated services exist. The purpose of this initiative is to stimulate planning for the development of different models of service systems that integrate physical and medical care services with mental health care and substance abuse prevention and treatment services, and that are congruent with the community-based needs of a population of children and adolescents and their families/caregivers.

1.3 Program Purpose and Goals

The OAH/MCHB/HRSA and the Centers of SAMHSA jointly announce the availability of funds to support the initiative, A*Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families.*@ These two year planning grants will provide start-up support for grantees to initiate and formalize working relationships among public and private community organizations/agencies/programs and/or state agencies and key stakeholders to establish a blueprint for the integration of primary health care and behavioral health services for children, adolescents and their families in a targeted area with a total population of 100,000 to 250,000 (which includes an estimated minimal population of children and adolescents of 25,000). The combined services are to include

physical health and medical care; promotion of mental health and mental health diagnostic and treatment services, substance abuse prevention, diagnostic and treatment services (behavioral health services) and related support and enabling services (e.g., case coordination; transportation; linkages to educational, family support, and community-based youth programming; and housing/training/employment assistance). The services integration plan should consider a continuum of care model with regard to services delivery. That is, applicants should consider the following service components in their planning efforts: Prevention, identification, early intervention, assessment, referral, treatment (allowing for out-patient, in-patient, and residential), and follow-up/maintenance/on-going care for physical health, medical, mental health and substance abuse problems. The program is intended to support the development of local integrated service delivery models that generate outcomes selected by the applicant for its own targeted population. Under this announcement, each grantee will engage in a strategic planning process and design an integrated services model that includes methods for securing financial sustainability through local and state, and public and private support. It is the intent of this initiative, given the availability of Federal funding resources at the end of the 2-year planning grant cycle, to position the funded communities for service system implementation and on-going development of integration efforts.

The four goals of the A*Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families*@ initiative are to: 1) support the development of models systems of quality care that integrate physical health and medical care, mental health care, and substance abuse prevention and treatment services and that encompass the continuum of preventive, interventive, treatment and maintenance services, including transition assistance; 2) position grantees for implementation, further development of services integration, and sustainability of the services system beyond Federal funding; and 3) strengthen grantees= capacity to evaluate the effectiveness of their own model service systems.

Based on these goals, the specific objectives of this initiative are to:

- Provide a structure that defines specific outcome expectations for services integration for children, adolescents and their families within the designated target community;

- Support the design of effective, integrated service system models to provide services that are developmentally appropriate, culturally responsive, and geared toward the unique needs of the target community, including responsiveness to its values and principles;

- Build supportive mechanisms that draw on private and public resources at the local, State, and national levels for assuring fiscal sustainability;

- Create a foundation for future outcome and process evaluations of the developed integrated service system models; and
- Enhance meaningful participation of families/caregivers, community organizations, health services providers, insurers and other stakeholders in planning and developing the integrated services system and treatment options.

In order to accomplish these goals and objectives, the initiative envisions creating service system designs that are both programmatically and fiscally feasible and that reflect the service outcome expectations unique to the applicant community.

1.4 Project Period and Availability of Funds

The project period is two years and begins on **July 1, 2000.** Up to $200,000 are available to support four planning grants during project year one at $50,000 per award. Subject to availability of funds, level funding is anticipated for the second project year.

1.5 Program Requirements

This program is intended to support a planning and design process for the development of integrated service system models. In order to produce the service system plan, grantees will be required to accomplish specific tasks based on strategic planning that targets specific service delivery outcomes which the grantee community wishes to seek for the population to be served.

As part of the planning process, the grant will also support production of measurable outcomes and prospective development of a reliable approach to evaluating the effectiveness of the service system.

Applicants should address the following specific tasks, which are outlined in Sections 1.5.1, 1.5.2, and 1.5.3. The tasks are generally congruent with the specific review criteria outlined in Section 2.2.

1.5.1 Understanding of the Proposed Project

Grantees under this program will implement a strategic planning and design process that yields a realistic integrated service system model which can be used to guide implementation, monitoring and evaluation, ongoing model modification responsive to feedback, and future system development. Applicants will need to:

- understand the issues relevant to the integration of physical health and medical care, mental health care, and substance abuse prevention and treatment services for children, adolescents and their families;

- understand the goals and objectives of the national program (i.e., initiative) defined in this Guidance and how their proposed project would contribute to achieving those goals and objectives;
- understand the issues specific to the target population and community that must be considered as part of planning for an integrated services model;

- have a clear and concise vision of services for the target population based on the service needs and outcome expectations of the target community; and

- understand the challenges, in terms of both opportunities and barriers, related to designing an integrated health services model.

1.5.2 Methodology: Planning and Designing the Integrated Services Model

The Project Plan will accommodate a planning process that results in an integrated service system model that: 1) is based on an understanding of the methodologies used for planning and designing effective, organized integrated service systems; 2) is comprehensive and inclusive of a continuum of care; 3) is founded on service outcome expectations; 4) is feasible from a resource and experiential perspective; and 5) can be reliably evaluated once implemented. The Project Plan, therefore, should include a planning and design approach with the following characteristics:

- Planning

  - an inclusive and participatory format that ensures engagement in and acceptance of the planning process and specific outcome expectations by key community (public and private) and/or State stakeholders (see example list in Section 1.5.3, "Project Requirements: Project Organization, Management and Resources"), including, for example, family members/caregivers, children and adolescents, community organizations, and health services providers.

- Design

  - an approach to organizing and assessing an integrated system of care for children, adolescents and their families/caregivers that includes physical health care and medical services, mental health services, substance abuse prevention and treatment services, and supportive and enabling services important to optimally meeting the comprehensive needs of the population (e.g., transportation; case coordination; linkages to educational, family support, and community-based youth programming; and housing/training/employment assistance).

  - a methodology that defines the measures of expected outcomes of service implementation and the feasibility of evaluating these outcomes.

  - a methodology that works for the applicant's community that can be relied upon to yield a clear description of the proposed integrated services system and its individual components.

Applicant entities are encouraged to design a model of integrated services that is suited to the needs of the target community. The comprehensive needs of sub-populations of children and adolescents that are not otherwise satisfactorily addressed by the community should be considered (e.g., children with special health care needs; children and adolescents under the supervision of juvenile court or in the foster care system; children and adolescents who do not attend school on a regular basis or who have dropped out of school).

Integration of services goes beyond mere co-location of professional staff in a health care setting. While geographic co-location of services is an important approach that may be well-suited to many communities and may help to simplify logistics issues, applicant entities are encouraged to consider additional approaches that would fit the unique needs of their community and target population. For example, applicants may design integrated services models or processes that include other settings as focal points (e.g., schools, detention facilities, foster care services) and may include cross-training opportunities, supervision and consultation, or interdisciplinary teams as a primary integration mode. A rural community may develop a plan for integrating physical health and speciality behavioral health services through expanded telemedicine opportunities. A community in which the majority of children's and adolescents' primary care is delivered in small, office-based settings may want to consider developing a unique approach to the design of an integrated services model.

The following dimensions, some of which overlap with each other, are important considerations to the successful planning and implementation of models that integrate clinical physical health and medical care, mental health care, and substance abuse prevention and treatment services. The applicant should describe how each dimension will be addressed in the planning process.

- Governance and executive leadership.
- Blending of organizational structures and staff; configurations of staff.
- Operations and management; accountability.
- Facilities and equipment; materials and supplies.
- Financing and allocation of resources; blending of funds and resources; fiscal management; fiscal sustainability.
- Legal and regulatory issues.
- Functioning in a managed care environment; integration of financing and services

delivery; coping with Acarve-outs@ for mental health and substance abuse prevention and treatment services.

- C Involvement and interactions among diverse disciplines; human resources development and management; organizational culture and work climate; relationships with external care providers.

- C Education, training and supervision of clinicians, administrators, and support staff; needs of health professions students and professionals-in-training.

- C Information systems and medical record keeping; confidentiality of patient information.

- C Quality assessment and strategies for improvement, evaluation (process and outcomes) and performance results.

- C Involvement of, support from and communication with the community; development of goodwill between the community and integrated services system; community=s understanding of the integrated services system=s mission and vision; liaison with community organizations and agencies.

- C On-going strategic planning for future development and growth; flexibility and responsiveness to a changing health care environment.

C Needs

- a process for assessing the needs of key players and stakeholders, including the target population of children, adolescents and their families/caregivers; the involved organizations and the community that they serve; and the professional staffs, trainees, and administrative staffs working in the stakeholding organizations.

C Outcomes

- a concrete process for establishing outcome expectations that the stakeholders will likely adopt.

- a process for assessing the cost of the current and proposed services, including cost offsets from other systems.

C Resources

- a resource strategy that creates a realistic framework for implementation and shows how community agencies/stakeholders will obtain and invest various resources, both public and private, into the integrated services system model with a goal of financial sustainability.

C Evaluation

- identification of the evaluation priorities that will be used to assess both the effectiveness of the implemented service system model (such as ranking priorities from among such topics as integrated service system access, rate of emergency department use, school success, juvenile justice involvement, family stability, change in service capacity, and cost offsets) and its level of functioning (such as ranking priorities from such topics as patient, community and staff satisfaction, level of clinical problem identification, accuracy and thoroughness of diagnosis, financial stability). Note that both outcome and process evaluations should be considered as part of the planning effort.

1.5.3 Project Organization, Management and Resources

The applicant will need to demonstrate that it has the capacity to engage all local and/or state agency stakeholders in the planning process. The capacity to carry out the overall project will include the following:

C Experience with similar projects;

C Experience with a population of children, adolescents and their families/caregivers;

C Qualifications and experience of the project leadership, including past endeavors that involved relationships with multiple stakeholders;

C Commitment to developing and sustaining working relationships among key stakeholders, with the goal of designing and ultimately implementing an integrated services program.

Three types of organizations, agencies or programs should demonstrate their full and mutual commitment to collaborate in and provide leadership to the planning process, and if funded, to pledge their commitment to implementation of the developed plan. The key collaborating organizations, agencies or programs include a health/medical care organization/agency/program, a mental health services organization/agency/program, and a substance abuse prevention and treatment services organization/agency/program. In addition, the applicant should include commitments from other key stakeholders to participate actively in the planning process. Intended stakeholders include but are not limited to children, adolescents and their

families/caregivers; community and/or State public health agencies; the array of primary care providers working in or in association with the leadership organizations/agencies/programs (such as physicians, nurses, nurse practitioners, physician assistants); speciality service providers working in or in association with the leadership organizations/agencies/programs (such as child, adult, family psychologists/psychiatrists, therapists, substance abuse and mental health counselors, and social workers); professionals serving the community=s physical health and mental health care needs whose practices are not directly affiliated with the leadership organizations/ agencies/programs; case coordinators; TANF, Medicaid, and SCHIP workers; administrators and managers in primary health care, mental health and substance abuse services settings; developmental specialists; education-related personnel; child protective and foster care services personnel; police and other justice system personnel; managed care organizations or other public and private insurance providers (health plan administrators), as well as other local public and private, business and not-for-profit, and youth-serving organizations designated by applicants as relevant to the development and support of the integrated services plan.

The application package should include demonstration of explicit leadership commitment to this collaborative project through a jointly signed letter from the directors of existing physical health/medical care, mental health services, and substance abuse prevention and treatment services organizations/agencies/programs. This letter should state: 1) which organization/ agency/program will be responsible for the grant award (that is, serve as the grantee and assume fiscal and managerial responsibility for the funding); 2) how project leadership will be organized; 3) commitment to full engagement in the planning process, and if selected for funding as part of this initiative, full commitment to the future implementation of the developed integrated services system model that was produced from the planning process. In addition, the proposal should include individual letters of commitment from other key stakeholders that the applicant envisions including in the planning process. Each letter should state the proposed role of the organization/agency/ program/individual in the planning process and commitment to active involvement in any future implemented activities. These letters should be contained in the Appendix, ACopies of Written Documentation.@

- Experience and commitment of any consultants and subcontractors;

- Reasonableness of the organizational structure, including its management information system, to carry out the project; and

- Reasonableness of the assumptions about resource utilization, including: 1) time frames for performance; 2) adequacy and availability of the resources proposed for each task (e.g., staffing, consultants, collaborating agencies, facilities, equipment); and 3) management plan.

CHAPTER II REVIEW CRITERIA AND PROCESS

2.1 General Criteria

The general criteria that follow are used, as pertinent, to review and evaluate applications for awards under all Health Resources and Services Administration (HRSA) programs as published in the *HRSA Preview for Grant Funding Opportunities* (volume 3, number 1, Fall, 1999). Further guidance in this regard is supplied by Section 2.2, ASpecific Review Criteria and Instructions for Preparing the Project Narrative,@ which specifies any variations from these general criteria.

- That the estimated costs to the Government of the project are reasonable considering the level and complexity of activity and the anticipated results.

- That project personnel or prospective fellows are well qualified by training and/or experience for the support sought and the applicant organization or the organization to provide training to a fellow has adequate facilities and manpower.

- That, insofar as practical, the proposed activities (scientific or other), if well executed, are capable of attaining project objectives.

- That the project objectives are capable of achieving the specific program objectives defined in the program announcement and the proposed results are measurable.

- That the method for evaluating proposed results includes criteria for determining the extent to which the project has achieved its stated objectives and the extent to which the accomplishment of objectives can be attributed to the project.

- That, in so far as practical, the proposed activities, when accomplished, are replicable, national in scope and include plans for broad dissemination.

The specific review criteria used to review and rate applications are outlined below in Section 2.2. Applicants should pay strict attention to addressing these criteria as they are the basis upon which their applications will be judged.

2.2 Specific Review Criteria and Instructions for Preparing the Project Narrative

The project narrative is restricted to **30 double-spaced pages**, using a font size of no more than15 characters per inch. Applications exceeding the page limitation will be returned to the applicant **WITHOUT REVIEW**. Appendices are not included in the 30 page limit but should be used only to provide supporting documentation, e.g., position descriptions, curriculum vitae/biographical sketches, and letters of commitment from participating agencies. All substantive information responding to the criteria must be contained within the project narrative. (See Section 4.6, APreparing the Appendices.@ There is a 50 page limit for appendices.)

Instructions for preparing each major section of the project narrative are followed by corresponding specific review criteria, which the Objective Review Panel will be instructed to use for their evaluation and rating of applications submitted to the initiative, *Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families*. Applicants are encouraged to organize their project narratives by the three major headings provided in Sections 2.2.1, 2.2.2, and 2.2.3.

2.2.1 Understanding of the Proposed Project: Background, Goals and Objectives

INSTRUCTIONS

- The applicant should summarize its understanding of issues relevant to the integration of physical health and medical care, mental health care and substance abuse prevention and treatment services for children and adolescents, including their families, in its targeted community. The applicant should describe the following: 1) the community proposed for inclusion in the project; 2) the overall physical and mental health status of children and adolescents living in the targeted community, including the health status of key sub-populations; 3) the physical and medical care needs, mental health service needs, and substance abuse prevention and treatment needs of children and adolescents living in the targeted community, including the needs of key sub-populations; and 4) the configuration and capacity of the community=s current delivery system(s) of health and medical, mental health, and substance abuse prevention and treatment services available to children, adolescents and their families, including key sub-populations.

- The applicant should describe its preliminary vision of the integrated services system it anticipates developing, basing it on the service needs and outcome expectations of the target community.

- The applicant should define its goals and measurable objectives for the project and describe how the proposed project, if fully successful, would contribute to achieving the goals and objectives defined in this Guidance for the national program. The project goals should reflect intended outcomes for each area. Each goal requires one or more explicit outcomes as (a) measure(s) of its achievement. Goals and objectives should not be confused. Goals are end products of an effective project. Objectives are measurable steps for reaching goals.

- The applicant should describe the challenges, in terms of both opportunities and barriers, that are related to designing an integrated health services model for children, adolescents and their families living in the target community.

SPECIFIC REVIEW CRITERIA

- The clarity with which the applicant describes the physical health and mental health status,

the service needs and the organization and status of the existing services for children, adolescents and their families/caregivers in the target community;

- The extent to which the applicant has a clear and concise vision of an integrated services model that is based on the service needs and outcome expectations of the target community;

- The extent to which the applicant understands the goals and objectives of the national program (initiative) defined in this Guidance and how the proposed project, if fully successful, would contribute to achieving those goals and objectives;

- The extent to which the applicant understands the challenges, in terms of both opportunities and barriers, related to designing an integrated service system for the children, adolescents and their families/caregivers living in its targeted community;

2.2.2 Methodology: Planning and Designing the Integrated Services Model

INSTRUCTIONS

The applicant should describe its intended methodologies for planning and designing an effective, integrated services system model for children, adolescents and their families living in the target community. The description should include:

1) how the participatory planning process will involve individuals and groups reflective of the community and target population in the preparation of the application;
2) how the planning process will assess the needs of the client population(s) consistent with outcome expectations;
3) how the plan will address age, developmental, racial/ethnic, cultural, language, gender, and community-specific (including the needs of specified sub-population groups) issues in the proposed service model design;
4) how the planning process will assess the needs of other key players and stakeholders, including, for example, community organizations, professional staffs, trainees, and administrative staffs, and community-based health care professionals not affiliated with the stakeholding organizations;
5) how the proposed planning methodology will be able to yield a clear description of the proposed model system and its individual components (see Section 1.5.2 for a list of the dimensions that the planning process should consider);
6) how the planning process will be able to address any problems and barriers associated with the community=s current health care delivery system(s) for children, adolescents and their families;
7) how the methodology will develop specific strategies for both outcomes and

process evaluations of the integrated services model, including attention to design and measurement; and

8) how resources will be utilized. It would be helpful for Applicants to indicate how specific project activities will accomplish or are linked to specific project objectives.

SPECIFIC REVIEW CRITERIA

- The extent to which the applicant understands the methodologies used for planning and designing effective, organized integrated services systems and service delivery for children, adolescents and their families.

- The extent to which the applicant has demonstrated an adequate participatory planning process, which involves groups and individuals reflective of the services community, the client population and provider service pool, in the preparation of the application;

- The extent to which the plan provides a process for documenting the current service system configuration and service delivery capacity;

- The extent to which the plan provides a process for assessing the needs of the client population consistent with the outcome expectations;

- The extent to which the process organizes and assesses a system of care for children, adolescents and their families;

- The extent to which the plan provides a design methodology that works for the designated community and can be relied upon to yield a clear description of the proposed system and its individual components;

- The extent to which the project plan addresses age, developmental, race/ethnic, cultural, language, gender, and other community-specific issues in the proposed service model design;

- The extent to which the plan provides a design methodology that defines the measures of expected outcomes of service implementation and the evaluability of these outcomes, as well as evaluating how well the model functions;

- The extent to which the application provides a plan to evaluate the outcomes of the planning process; and

- The extent to which the resource and utilization strategy is a realistic framework for design implementation.

2.2.3 Project Organization, Management, and Resources

INSTRUCTIONS

- The applicant should describe:

    1) the qualifications and experience of the project director and other key personnel as well as the capability, experience and evidence of commitment of proposed consultants and subcontractors;
    2) the experience of the key project staff and collaborating organizations/ agencies/programs in providing physical health and medical care, mental health care, and substance abuse prevention and treatment services to populations of children, adolescents and their families;
    3) any previous experiences in designing health care systems and in integrated services models;
    4) any previous efforts that involved relationships with multiple stakeholders; and
    5) previous working relationships, if any, among the collaborating and cooperating organizations, agencies, and programs.

- The applicant should describe the proposed project=s organizational structure, including its relationships:

    1) to the sponsoring organizations,
    2) among project personnel,
    3) among collaborating and cooperating agencies, and
    4) with the target community.

    The applicant should address mechanisms for obtaining and sustaining interagency coordination and collaboration. The project should describe its intended governance structure.

- The applicant should affirm the commitment of each collaborating and cooperating agency to the project, and should describe the intended roles that each agency will play in the project. (Note that letters of commitment, as described in Section 1.5.3, should be attached as part of the Appendix, ACopies of Written Documentation.@)

- The applicant should describe its resources for accomplishing the project, including its facilities and physical space, equipment, and information technology resources.

- The applicant should describe its plan for managing the project, including its personnel and

resources. It should describe its plan for monitoring and tracking project activities.

SPECIFIC REVIEW CRITERIA

- Qualifications and experience of the project director and other key personnel;
- Commitment of proposed partners, consultants and subcontractors;
- Project=s organizational structure, including mechanisms for obtaining and sustaining interagency coordination and collaboration;
- Project in terms of: 1) time frames, 2) adequacy and availability of resources (e.g., staffing, consultants, collaborating agencies, facilities, equipment) and 3) management plan;
- Management and staffing plan; other resources and personnel, including attention to age, gender, developmental, race/ethnicity and cultural factors related to the target population.

2.2.4 Budget

Although the reasonableness and appropriateness of the proposed budget for each year of the proposed project are not specific review criteria for this Guidance, they will be considered after the merits of the application have been considered. See Sections 4.3.1, 4.3.2, and 4.3.3 for instructions on preparation of the budget.

2.3 Review Process

A multidisciplinary panel of outside experts will review and evaluate all complete applications. The evaluation of each individual application will be based on two sets of criteria: 1) the quality of each required section of the project narrative (see Section 2.2 of the Guidance); and 2) the program specific requirements (see Sections 1.5, 1.6, 2.1 and 2.2 of the Guidance).

At least two members of the objective review panel will evaluate each application in its entirety. All other panel members will read the application abstract and have the opportunity to review the entire application. After the two reviewers present their analyses and the panel discusses the application, all panel members will vote for a recommendation of approval or disapproval. Applications recommended for approval are rated by each panel member against a hypothetically ideal project. This rating forms the basis for selection of applicants for this initiative. Any panelist who has a conflict of interest regarding a given application is excused from the panel during the presentation, discussion, and voting of that particular application.

2.4 Award Decision Criteria

Final funding decisions for SPRANS grants are the responsibility of the Associate Administrator for Maternal and Child Health. In considering scores for the ranking of approved applications for funding, preferences may be exercised for groups of applications (e.g., competing continuations may be funded ahead of new projects). Within any category of approved projects, the score of an individual project may be favorably adjusted if the project addresses specific priorities identified in Section 1.1 of this Guidance under the Maternal and Child Health Bureau Mission Statement. In addition, special consideration will be given for the following:

- Availability of funds.
- Evidence of non-supplantation of funds.
- Evidence of commitment by the identified state and local stakeholders through letters of commitment/memoranda of agreement.
- Evidence of formal coordination/collaboration with a Federal and/or non-Federal organization that has the recognized capacity to provide resources to support/assist in this project.
- Relevance of the project to the MCHB/HRSA and SAMHSA program priorities and balance.
- Equitable distribution of awards in terms of geography, project size and rural/urban locality.

CHAPTER III ELIGIBILITY, PROCEDURE AND REQUIREMENTS

3.1 Who Can Apply for Funds

SPRANS Grants: Any public or private entity, including Indian tribes or tribal organizations (as those terms are defined at 25 U.S.C. 450b) is eligible to apply for Federal funding under this initiative, which is supported by the MCHB=s *Special Projects of Regional and National Significance (SPRANS)* program.

3.2 Application Procedures

The MCHB/Office of Adolescent Health has made approximately $200,000 available during fiscal year 2000 for four awards for planning grants under the initiative, *Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families*. The project grant period may be approved for up to 2 years with annual continuation awards subject to satisfactory progress and the availability of funds. The anticipated date of award, or starting date, is **July 1, 2000**.

3.2.1 Due Date

The application deadline date for the initiative, *Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families* is **May 16, 2000**. Applications will be considered as meeting the deadline if they are: 1) received on or before the deadline date; or 2) are postmarked on or before the deadline date and received in time for orderly processing and submission to the review committee. (Applicants should request a legibly dated receipt from a commercial carrier or U.S. Postal Service postmark. Private metered postmarks will not be acceptable as proof of timely mailing.) Late applications will be returned to the applicant.

3.2.2 Letter of Intent

If you intend to submit an application for this grant program, please notify the MCH Bureau by**April 13, 2000**. The purpose of this notification is to help the MCH Bureau plan for the objective review process. It is not legally necessary to notify the MCHB of your organization=s intent to submit an application but it would greatly assist the Bureau=s planning efforts. You may notify your intent to apply by telephone, e-mail or postal service to:

Tel: Trina Menden Anglin, M.D., Ph.D. **or** Sue Martone, M.P.A.
(301) 443-4291 (301) 443-4996

E-Mail: tanglin@hrsa.gov smartone@hrsa.gov

Mail: Office of Adolescent Health
Division of Child, Adolescent and Family Health
Maternal and Child Health Bureau
Parklawn Building, Room 18A-39
5600 Fishers Lane
Rockville, Maryland 20857

Division of Child, Adolescent and Family Health
Maternal and Child Health Bureau
Parklawn Building, Room 18A-30
5600 Fishers Lane
Rockville, Maryland 20857

3.2.3 Electronic Access

Federal Register notices and application guidance for MCHB and SAMHSA programs are available on the respective websites: http://www.mchb.hrsa.gov or **http://www.samhsa.gov**. Click on the file format you desire, either WordPerfect 6.1 or Adobe Acrobat (the Adobe Acrobat Reader is also available for downloading from the MCHB Homepage).

If you have difficulty accessing the MCHB Homepage via the World Wide Web and need technical assistance, please contact ***Alisa Azarsa at (301) 443-8989 or aazarsa@psc.gov.***

3.2.4 Official Application Kit

If applicants are unable to access application materials electronically, as explained in Section 2.2.3, a paper copy of the official grant application kit should be obtained from the **HRSA Grants Application Center at the address listed in Section 3.2.6.** The HRSA Grants Application Center staff will acknowledge and confirm, in writing, receipt of the application.

3.2.5 Copies Required

Applicants are required to submit one ink-signed original and two copies of the completed application. Although not required, an additional four copies (which totals one original plus 6 copies) will facilitate the review process.

3.2.6 Mailing Address

All applications should be mailed or delivered to:

HRSA Grants Application Center
Attention: Curtis Colston
CFDA# 93.11AF
1815 N. Fort Myer Drive, Suite 300
Arlington, Virginia 22209

Telephone: 1-(877) HRSA-123
Fax: 1- (877) HRSA-345
E-mail address: hrsagac@hrsa.gov

3.3 MCHB Requirements

EXCEPT WHERE NOTED, APPLICANTS MUST MEET THE REQUIREMENTS LISTED BELOW. IF AN APPLICANT FAILS TO MEET THESE REQUIREMENTS, THE APPLICATION MAY NOT BE ACCEPTED FOR REVIEW AND MAY BE RETURNED TO THE APPLICANT.

3.3.1 Complete Required Application Standard Forms and Provide Budget Justification

It is required that applicants submit on supplemental sheet(s) a justification for each individual budget category itemized. Applicants typically identify the specific needs, but often fail to write a justification of those needs. These detailed budget justifications require the applicant to show specific references to the project plan related to how the requested dollar amount was developed. Applicants are not required to submit copies of contracts; however, personnel, scope of work, budgets, and budget justifications of contracts are required for grants management review.

As part of our efforts to streamline the overall granting process, a separate budget is required for each budget year requested. For example, if the applicant organization requests two years of grant support, three budget pages (the two pages of Form 424A, Budget Information - Non-Construction Programs and justification) are required for each year. The annual budget request and justification provides the budget information needed for the following year=s Summary Progress Report (see Section 3.3.3).
Proposals submitted without a budget and justification for each budget year requested may not be favorably considered for funding. (This information is also provided in Section 4.3.2)

3.3.2 Public Health System Reporting Requirements

With exception for MCH Research and Training, all programs are subject to the Public Health System Reporting Requirements (approved under OMB No. 0937-0195). Under these requirements, the community-based nongovernmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based nongovernmental organizations within their jurisdictions.

Community-based nongovernmental applicants are required to submit the following information to the head of the appropriate State and local health agencies in the area(s) to be impacted no later than the Federal application receipt due date:

(a) A copy of the face page of the application (SF 424);
(b) A summary of the project (PHSIS), not to exceed one page, which provides:

(1) A description of the population to be served.
(2) A summary of the services to be provided.
(3) A description of the coordination planned with the appropriate State and local health agencies.

It is also permissible to substitute the Project Abstract in place of the PHSIS. If the applicant chooses this option, the procedure to follow can be found in Chapter 4, Section 4.5.

3.3.3 Future Reporting Requirements

A successful applicant under this notice will submit reports in accordance with the provisions of

the general regulations that apply (AMonitoring and Reporting Program Performance@ 45 CFR Part 74.51 and Part 92.40). Successful applicants will be required to provide an annual progress report. The progress report will be included in the continuation application each year. The progress report should include: (1) a brief summary of overall project accomplishments during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them; (2) progress on specific goals and objectives as outlined in this application and revised in consultation with the Federal project officer; (3) current staffing, including the roles and responsibilities of each staff and a discussion of any difficulties in hiring or retaining staff; (4) technical assistance needs; and (5) a description of linkages that have been established with other programs.

3.4 Policy Issuances

3.4.1 Healthy People 2010

The Health Resources and Services Administration (HRSA), MCHB and SAMHSA are committed to achieving the health promotion and disease prevention objectives of Healthy People 2010, a HRSA-led national activity for setting priority areas. Applicants may obtain *Healthy People 2010* online at:

http://www.health.gov/healthypeople/Document/tableofcontents.htm#Volume.

The text version of *Healthy People 2010* is not yet available. However, the preceding *Healthy People 2000* document may be obtained through the Superintendent of Documents, Government Printing Office Washington, DC 20402-9325 (telephone: (202) 512-1800): *Healthy People 2000* Full Report: Stock No. 017-001-00474-0 or *Healthy People 2000* Summary Report: Stock No. 017-001-00473-1.

3.4.2 Smoke-Free Environment

HRSA and SAMHSA strongly encourage all grant recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

3.4.3 Special Concerns

HRSA and SAMHSA place special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. In order to assure access and cultural competence, it is expected that projects will involve individuals from the populations

to be served in the planning and implementation of the project. The intent is to ensure that project interventions are responsible to the cultural and linguistic needs of special populations, that services are accessible to consumers, and that the broadest possible representation of culturally distinct and historically under-represented groups is supported through programs and projects sponsored by the Federal Government.

3.4.4 Evaluation Protocol

Evaluation and self-assessment are critically important for quality improvement and assessing the value-added contribution of Title V investments. Consequently, discretionary grant projects are expected to incorporate a carefully designed and well planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals. The measurement of progress toward goals should focus on systems, health and performance outcome indicators, rather than on intermediate process measures.

The protocol should be based on a clear rationale relating to the identified needs of the target population with grant activities, project goals, and evaluation measures. A project lacking a complete and well-conceived evaluation protocol may not be funded.

3.4.5 Cultural Competence Language

Cultural competence is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time. For a more detailed, descriptive definition, refer to the Glossary, Enclosure D.

3.4.6 Year 2000 Compliance

The Year 2000 computer problem is an important concern for all health care providers. As a HRSA and SAMHSA grantee, you are not only responsible for the services you provide, but also for the programmatic, administrative and financial functions that support these services. As a result, you must take all steps necessary to ensure your computer systems function properly into the year 2000.

3.5 Checklist

Refer to the AChecklist@ on the next page for a complete listing of all components to be included in the application.

CHECKLIST FOR COMPETITIVE APPLICATION

FY 2000

SUBMIT 1 ORIGINAL, INK-SIGNED APPLICATION AND 2 SIGNED COPIES, ALL NUMBERED AND UNBOUND (FOR EASE OF COPYING). INCLUDE THE FOLLOWING:

1. Letter of Transmittal
2. Table of Contents for Entire Application with Page Numbers

Budget Information

3. ____ SF 424 Application for Federal Assistance
4. ____ ***Checklist Included with PHS 5161-1.*** Provide the Names, Addresses, and Telephone Numbers for Both the Individual Responsible for Day-to-Day Program Administration and the Finance Officer
5. ____ SF 424A Budget Information -- Non-Construction Programs
6. ____ Budget Justification
   (Includes the Budget Narrative, Supplemental Sheets and Key Personnel Form and Appropriate Attachments)

Federal Assurances

7. ____ Intergovernmental Review under E.O. 12372, if Required by State
8. ____ SF 424B Assurances -- Non-Construction Programs
9. ____ Department Certification (45 CFR Part 76)
10. ____ Certification Regarding Drug-Free Workplace Requirements
11. ____ Certification Regarding Debarment and Suspension
12. ____ Lobbying Certification
13. ____ Public Health System Impact Statement

Description of Program

14. ____ Project Abstract, Maximum of 2 Pages ***(Label as ATTACHMENT A)***
15. ____ Project Narrative, Maximum of 30 Pages
16. ____ Appendices, Maximum of 50 Pages

CHAPTER IV INSTRUCTIONS FOR COMPLETING THE APPLICATION

4.1 How to Organize the Application

You should assemble the application in the order shown below:

- Table of contents for entire application with page numbers
- SF-424 Application for Federal Assistance
- Checklist included with the PHS 5161-1
- SF 424A Budget Information--Non-Construction Programs
- Budget Justification
- Key Personnel form (Attachment C)
- Federal Assurances (SF 424B)
- Project Abstract (Attachment A)
- Project Narrative
- Appendices
- Project Personnel Allocation Chart (Attachment D)

4.2 Application Assistance

Applicants are encouraged to request assistance in the development of the application.

For additional information regarding business, administrative, or fiscal issues related to the awarding of a grant under the Guidance for this initiative, *Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families*, applicants may contact:

Mr. Curtis Colston
Grants Management Specialist
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 18-12
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: (301) 443-3438
Fax: (301) 443-6686
E-mail: ccolston@hrsa.gov

To obtain additional information relating to technical and program issues under this program, applicants may contact:

Sue Martone
Public Health Analyst
Division of Child, Adolescent and Family Health
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 18A-30
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: (301) 443-4996
Fax: (301) 443-1296
E-Mail: smartone@hrsa.gov

Additional assistance can also be obtained from the HRSA Regional/Field Offices (see Enclosure A).

4.3 Overview of Required Application Forms and Related Program Concerns

The application Form PHS-5161-1 is the official document to use when applying for an grant under the *Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families*. The Form PHS 5161-1 is composed of seven sections, which are described more fully on page 1 of the APublic Health Service Grant Application Form PHS-5161-1@ (revised 6/99) in section one, which is entitled AGeneral Information and Instructions.@

Please submit an original ink-signed and two copies of each of the following:

Grant Application Form PHS-5161-1: a) Application for Federal Assistance-Standard Form (SF) 424; b) Budget Information - Non-Construction Programs, SF-424A; c) Assurances - Non-Construction Programs, SF-424B; d) Certifications; e) Checklist including administrative official and individual responsible for directing the program/project; and f) Public Health System Impact Statement.

4.3.1 Budget

For each part of Form PHS 5161-1, 6025-1, or 398, it is required that applicants submit on supplemental sheet(s) a justification for each individual budget category itemized. Applicants typically identify the specific needs, but often fail to write a justification of those needs. These detailed budget justifications require the applicant to show specific references to the project plan related to how the requested dollar amount was developed. Applicants are not required to submit copies of contracts; however, personnel, scope of work, budgets, and budget justifications of contracts are required for grants management review.

4.3.2 Consolidated Budget

As part of our efforts to streamline the overall granting process, a separate budget is required for each budget year requested. For example, if the applicant organization requests two years of grant support, three budget pages (the two pages of Form 424A, Budget Information - Non-Construction Programs and justification) are required for each year. The annual budget request and justification provide the budget information needed for the following years Summary Progress Report (see Section 3.3.3, Future Reporting Requirements). **Proposals submitted without a budget and justification for each budget year requested may not be favorably considered for funding**. (This information is also provided in Section 3.3.1.)

The Key Personnel Form, Attachment C, may be used as a supplement to the Budget Narrative. Key personnel can be identified by name (if known), total percent of time and salary required under the grant, and if applicable, amounts provided by in-kind or by other sources of funds (including other Federal funds) to support the position. The budget justification for personnel addresses time commitment and skills required by the project plans. Similar detailed and itemized justifications must be provided for requested travel items, equipment, contractual services, supplies and other categories and for indirect costs.

4.3.3 Indirect Costs

Please note that if indirect costs are requested, the applicant must submit a copy of the latest negotiated rate agreement. The indirect costs rate refers to the "Other Sponsored Program/Activities" rate and to neither the research rate nor the education/training program rate.

4.4 How to Format the Application

MCHB prefers that the format and style of each application substantially reflect the format and style described in this guidance. To promote readability and consistency in organization, MCHB has established specific conventions for the format of the project abstract, the project narrative and appendices. Conventions for each are discussed below. Wherever conventions for the individual parts of the grant proposal differ, the parts are discussed separately. Otherwise, the specific convention applies to all parts of the grant proposal.

A clearly written and easy-to-read grant proposal should be the goal of every applicant since the outcome of the review process depends on information provided in the application narrative. Therefore, MCHB urges all applicants to review their applications for the following:

$ Correct grammar, spelling, punctuation, and word usage.

- Consistency in style. Refer to a good style manual, such as *The Elements of Style* by William Strunk, Jr. and E. B. White; *Words into Type*, *The Chicago Manual of Style;* or the Government Printing Office=s *A Manual of Style*.

- Consistency of references (e.g., in this guidance document the MCH Bureau is initially called the Maternal and Child Health Bureau (MCHB), and subsequent references to it are MCHB.

- **Typeface** -- Use any easily readable typeface, such as Times New Roman, Courier, or New Century Schoolbook.

- **Type Size** -- Size of type must be at least 12-point. Type density must be no more than 15 characters per inch. No more than six lines of type must be within a vertical inch. Figures, charts, legends, footnotes, etc., may be smaller or more dense than required above but must be readily legible.

- **Margins --** The initial left and all right margins should be 1 inch. The left margin may change when using the decimal ranking illustrated and described below. Top and bottom margins should be 1.25 inches each.

- **Page Numbering**

  - **Project Abstract** -- Consecutive, lowercase Roman numerals should appear centered at the bottom of the appropriate page. These should be a continuation of the numbering of the Table of Contents.

  - **Project Narrative** -- Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page. They should paginate all charts or figures appearing within the body of the text consecutively with the text.

  - **Application Tables** -- Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page. All information presented in tabular form should be paginated.

  - **Appendices** -- Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page.

- **Table of Contents** -- A Table of Contents is required. Use the Table of Contents of this Guidance as a formatting and style guide.

- **Page Limit and Spacing** -- If an application exceeds the limits specified below, it is subject to being returned without review.

4.5 Project Abstract

The Project Abstract (label as Attachment A) of all approved and funded applications will be published in the Maternal and Child Health Bureau=s (MCHB) annual publication entitled *Abstract of Active Projects*. This publication, which includes summaries of all projects funded by MCHB, is updated annually and is an important mechanism for disseminating information about MCHB-funded projects. It is widely distributed to MCHB grantees, Title V programs, academic institutions, and government agencies. Please refer to Enclosures B and C for instructions.

This two page abstract may be submitted in lieu of the Public Health System Impact Statement (PHSIS) described in Section 3.3.2, Public Health System Reporting Requirements.

4.5.1 Format Guidelines

- Use plain white paper (not stationery or paper with borders or lines).
- Single-space your abstract.
- Avoid Aformatting@ (do not underline, use bold type or italics, or justify margins).
- Use a standard (nonproportional) 12-pitch font or typeface such as courier.
- Type section headings in all capital letters followed by a colon. Double-space after the heading and begin the narrative flush with the left-margin. There is no space limitation on sections, but the abstract itself should not exceed two pages. Sections should be single-spaced with double-space between section headings, i.e., Problem(s), Goals and Objectives, Methodology, Evaluation, Coordination, and Key Words.

4.5.2 Project Identifier Information

Project Title: List the title as it appears on the Notice of Grant Award.
Project Number: This is the number assigned to the project when funded.
Project Director: The name and degree(s) of the project director as listed on the grant application.
Phone Number: Include area code, phone number, and extension if necessary.
E-mail address: Include electronic mail addresses (Internet, CDC Wonder, HandsNet, etc.)
Contact Person: The person who should be contacted by those seeking information about your project.
Grantee: The organization which receives the grant.
Address: The complete mailing address.
Phone Number: Include area code, phone number, and extension if necessary.
Fax Number: Include the fax number.
World Wide Web: If applicable, include your project's web site address.

Project Period: Include the entire funding period for the project, not just the one year budget period.

4.5.3 Text of Abstract

Prepare a two page (single-spaced) description of your project, using the following headings:

PROBLEM: Briefly (in one or two paragraphs) state the principal health problems, status, or issues which are addressed by your project.

GOALS AND OBJECTIVES: Identify the major goals and objectives for the project period. Typically, projects define the goal in one paragraph and present the objectives in a numbered list.

METHODOLOGY: Describe the programs and activities used to attain the goals and objectives, and comment on innovation, cost, and other characteristics of the methodology.

COORDINATION: Describe the coordination planned and carried out, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.

EVALUATION: Briefly describe the evaluation methods that will be used to assess the effectiveness and efficiency of the project in attaining its goals and objectives.

4.5.4 Key Words

Key words are the terms under which your project will be listed in the subject index of the abstracts book. Select significant terms which describe the project, including populations served, from the list contained in Enclosure C.

4.5.5 Submitting Your Abstract

The National Center for Education in Maternal and Child Health (NCEMCH) will prepare the abstract for publication. It is very important that you submit a disk of your abstract along with an original hard copy, rather than a photocopy, of the abstract. NCEMCH can convert many different software packages. Simply indicate which package you have used by writing the name of the package on the disk's label.

4.6 Preparing the Appendices

Appendices -- Appendices must not exceed 50 pages and must include all supporting documentation, such as (1) curricula vitae, (2) job descriptions, (3) letters of commitment and memoranda of agreement (Appendix should be labeled ACopies of Written Documentation,@ (4) evaluation tools, (5) protocols, (6) organizational charts, (7) timelines, and (8) reference citations. Job descriptions and curricula vitae

must not exceed two pages each. Spacing will vary depending on the nature of the appendix, but only one-sided pages are acceptable. Appendices should be brief and supplemental in nature.

AN APPLICATION WITH APPENDICES THAT EXCEED THE MAXIMUM NUMBER OF PAGES WILL NOT BE ACCEPTED FOR REVIEW AND WILL BE RETURNED TO THE APPLICANT.

Do not include pamphlets or brochures in the application package unless they were specifically created for the project. Refer to style and format, Section 4.4 of this chapter for specific conventions to be followed in formatting appendices. Examples of useful items include the following:

- **Organizational Chart(s)** *(necessary to include)* -- Include internal relationships of project staff, the relationships between project staff and any advisory boards, and the placement of the project within the structure of its parent organization(s).

- **Timelines** *(necessary to include)* -- Timelines for duration and completion of specific project activities, organized by objective.

- **Rosters of Board, Executive Committee, or Advisory Council Members** -- Include indications of consumer representation.

- **Copies of Written Documentation** *(necessary to include)* -- Descriptions of relationships between the proposed program and affiliated departments, institutions, agencies, or individual providers, family members or consumer advocacy groups, and the responsibilities of each. Examples of documentation include: Letters of commitment; memoranda of agreement.

- **Job Descriptions** *(necessary to include)* -- Descriptions of responsibilities for all professional and technical positions for which grant support is requested and any positions of significance to the program that will be supported by other sources. Job descriptions reflect the functional requirements of each position, not the particular capabilities or qualifications of given individuals. Each job description should be separate and must not exceed two pages in length. At a minimum, be sure to spell out the following:

    - Administrative direction and to whom it is provided;

    - Functional relationships (e.g. to whom the individual reports and how the position fits within its organizational area in terms of training and service functions);

    - Duties and scope of responsibilities; and

    - Minimum qualifications (e.g. the minimum requirements of education, training, and

experience needed to do the job).

- **Curricula Vitae** *(necessary to include)* -- Include vitae for each incumbent in a position for which a job description is submitted. Each curriculum vitae must not exceed two pages. The Biographical Sketch included in Attachment B may be used for this purpose.

- **Reference Citations** -- A list of reference citations and materials consulted by the applicant in preparation of the proposal may be summarized as an Appendix. Either a consecutive numbering system or an alphabetical system based on the authors= surnames should be used to link each reference to the pertinent narrative text. (An alternative method is to provide complete reference citations as footnotes on the relevant pages of the proposal=s narrative.)

HRSA REGIONAL/FIELD OFFICES **Enclosure A**
MATERNAL AND CHILD HEALTH

Region I (CT, ME, MA, NH, RI, VT)

Barbara Tausey, M.D., M.H.A.
Room 1826
John F. Kennedy Federal Building
Boston, Massachusetts 02203
Phone: 617-565-1433
Fax: 617-565-3044
BTAUSEY@HRSA.GOV

Region II (NJ, NY, PR, VI)

Margaret Lee, M.D.
26 Federal Plaza
Federal Building, Rm. 3835
New York, NY 10278
Phone: 212-264-2571
Fax: 212-264-2673
MLEE@HRSA.GOV

Region III (DE, DC, MD, PA, VA, WV)

Victor Alos, D.M.D., M.P.H.
Health Resources Northeast Cluster
Public Ledger Building
150 S. Independence Mall West
Suite 1172
Philadelphia, Pennsylvania 19106-3499
Phone: 215-861-4379
FAX: 215-861-4338
VALOS@HRSA.GOV

Region IV (AL, FL, GA, KY, MS, NC, SC, TN)

Ketty Gonzalez, M.D., M.P.H.
HRSA Field Coordinator, Southeast Cluster
Atlanta Federal Center
61 Forsyth Street, S.W. Suite 3M60
Atlanta, Georgia 30303-8909
Phone: 404-562-7980
FAX: 404-562-7974
KGONZALEZ@HRSA.GOV

Region V (IL, IN, MI, MN, OH, WI)

Dorretta Parker, M.S.W.
HRSA Midwest Field Office
233 North Michigan Avenue, Suite 200
Chicago, Illinois 60601-5519
Phone: 312-353-4042
FAX: 312-886-3770
DPARKER@HRSA.GOV

Region VI (AR, LA, NM, OK, TX)

Thomas Wells, M.D., M.P.H.
1301 Young Street
10th Floor, HRSA-4
Dallas, Texas 75202
Phone: 214-767-3003
FAX: 214-767-3038
TWELLS@HRSA.GOV

Region VII (IA, KS, MO, NE)

Bradley Appelbaum, M.D., M.P.H.
Federal Building, Room 501
601 East 12th Street
Kansas City, Missouri 64106-2808
Phone: 816-426-2924
FAX: 816-426-3633
BAPPELBAUM@HRSA.GOV

Region VIII (CO, MT, ND, SD, UT, WY)

Joyce G. DeVaney, R.N., M.P.H.
Federal Office Building, Rm 1189
1961 Stout Street
Denver, Colorado 80294
Phone: 303-844-3204
FAX: 303-844-0002
JDVANEY@HRSA.GOV

Region IX (AZ, CA, HI, NV, AS, FM, GU, MH, MP, PW)

Reginald Louie, D.D.S.
Federal Office Building, Room 317
50 United Nations Plaza
San Francisco, California 94102
Phone: 415-437-8101
FAX: 415-437-8105
RLOUIE@HRSA.GOV

Region X (AK, ID, OR, WA)

Margaret West, Ph.D., M.S.W.
Mail Stop RS-27
2201 Sixth Avenue, Room 700
Seattle, Washington 98121
Phone: 206-615-2518
FAX: 206-615-2500
MWEST@HRSA.GOV

Enclosure B

INSTRUCTIONS TO NEW GRANTEES: HOW TO PREPARE ABSTRACTS AND ANNOTATIONS FOR THE FIRST GRANT YEAR

(different guidelines apply for abstracts prepared in subsequent years of the grant)

Guidelines for preparing your abstract

Provide an abstract that can be published in the Maternal and Child Health Bureau=s (MCHB) annual publication, *Abstracts of Active Projects Funded by MCHB*. This publication, which includes summaries of all projects funded by MCHB, is updated annually and is an important mechanism for disseminating information about MCHB-funded projects.

Guidelines follow to assist you in preparing acceptable abstracts for publication. In general, please note:

- Abstracts should be two page descriptions of the project
- Use plain paper (not stationery or paper with borders or lines).
- Double-space your abstract.
- Avoid Aformatting@ (do not underline, use bold type or italics, or justify margins).
- Use a standard (nonproportional) 12-pitch font or typeface such as courier.

1. Project Identifier Information

Project Title:	List the appropriate shortened title for the project.
Project Number:	This is the number assigned to the project when funded.
Project Director:	The name and degree(s) of the project director as listed on the grant application.
Contact Person:	The person who should be contacted by those seeking information about your project.
Grantee:	The organization which receives the grant.
Address:	The complete mailing address.
Phone Number:	Include area code, phone number, and extension if necessary.
Fax Number:	Include the fax number.
E-mail address:	Include electronic mail addresses (Internet, CDC Wonder, HandsNet, etc.)
World Wide Web Address:	If applicable, include the address for you project=s World Wide Web site on the Internet.
Project Period:	Include the entire funding period for the project, not just the one-year budget period.

2. Text of Abstract

Prepare a two page (double-spaced) description of your project, using the following headings:

PROBLEM: Briefly (in one or two paragraphs) state the principal health problems, status, or issues which are addressed by your project.

GOALS AND OBJECTIVES: Identify the major goals and objectives for the project period. Typically, projects define the goal in one paragraph and present the objects in a number list.

METHODOLOGY: Describe the programs and activities used to attain the goals and objectives, and comment on innovation, cost, and other characteristics of the methodology. This section is usually several paragraphs long and describes the activities that have been proposed or are being implemented to achieve the stated goals and objectives. Lists with numbered items are sometimes used in this section.

COORDINATION: Describe the coordination planned and carried out, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.

EVALUATION: Briefly describe the evaluation methods which will be used to assess the effectiveness and efficiency of the project in attaining its goals and objectives. This section is usually one or two paragraphs in length.

3. Key Words

Key words are the terms under which your project will be listed in the subject index of the abstracts book. Select significant terms which describe the project, including populations served. A list of key words used to classify active projects is enclosed. Choose keywords from this list when describing your project.

Guidelines for Preparing Your Annotation

Prepare a three- to five-sentence description of your project which identifies the project=s purpose, the needs and problems which are addressed, the goals and objectives of the project, the activities which will be used to attain the goals, and the materials which will be developed.

Submitting your abstract and annotation

The National Center for Education in Maternal and Child Health (NCEMCH) will prepare the abstract for publication. Thus, if at all possible, it is **very** important that you submit a disk of your abstract (and annotation) along with a hard copy. NCEMCH can convert may different software packages. Simply indicate which package you have used by writing the name of the package on the disk=s label.

Send an original, rather than a photocopy, of the abstract and the annotation. If you cannot send a disk, it may be possible to scan the document and thus avoid the need to re-key the text.

Enclosures

Sample abstract
List of key words

Enclosure C

Sample NEW Abstract

(This abstract is presented as a sample format, not as a guide to content preparation.)

Project Title:	Healthy Families Manitowoc County
Project Number:	MCJ 55KL01
Project Director:	Amy Wergin, R.N.
Contact Person:	
Grantee:	Manitowoc County Health Department
Address:	823 Washington Street Manitowoc, WI 54220
Phone Number:	(414) 683-4155
Fax Number:	(414) 683-4156
E-mail Address:	WERG100W@WONDER.EM.CDC.GOV
World Wide Web address:	
Project Period:	10/01/97 - 09/30/01

Abstract:

PROBLEM: The health care system in Manitowoc County is changing dramatically as the State institutes Medicaid managed care in a community in which before April 1996 there were no active HMOs. Not only are the recipients of care experiencing change, but the entire health care system is looking at providing health care in a totally different atmosphere. Preventable hospitalizations of children are 41-percent higher and asthma hospitalizations of children are 24-percent higher than the State average. The incidence of child abuse and neglect in Manitowoc County is consistently higher than the State of Wisconsin and other comparable counties in the State. Research over the last 2 decades has consistently confirmed that providing education and support services around the time of the baby's birth, and continuing for months or years afterward significantly reduces the risk of child abuse and contributes to positive, healthy child-rearing practices, including increased use of preventive health care.

Manitowoc County has completed a preliminary assessment of parenting education and support

resources and has determined that although there are services available for parents, they are not coordinated, are initiated too late, and are not accessible to all county residents.

GOALS AND OBJECTIVES: The goal is to develop and implement universally offered, integrated, coordinated, collaborative, prevention-based, in-home visitation program for the first-time families of Manitowoc County based on the Healthy Families America model and to increase local capacity and commitment to provide these supportive services. These objectives will be used to attain the goal:

1. Increase the number of first-time families who access preventive health care for their children;
2. Reduce the incidence of preventable hospitalizations in targeted families; and
3. Reduce the incidence of child abuse and neglect in targeted families.

METHODOLOGY: A program manager will be hired to assist the Healthy Families Subcommittee of the Parenting Task Force of the Manitowoc County Asset-Building Community Initiative to develop and implement a collaborative in-home visitation service for first-time families of Manitowoc County. The program manager will complete the assessment of existing resources; facilitate the formation of agreements between services providers to actively collaborate; design a workplan to implement the Healthy Families Manitowoc County program based on the national model using "best practice" methodology, clear and measurable objectives, and an ongoing evaluation process; secure the funding needed, with the assistance of the consortium, for additional in-home visitation services needed to implement Healthy Families Manitowoc County; and be responsible for the implementation of the Healthy Families Manitowoc County Initiative.

COORDINATION: Healthy Families Manitowoc County will be a collaborative project that is a component of the Asset-Building Community Initiative of Manitowoc County. Stakeholders in the initiative are the Manitowoc County Health Department, Manitowoc County Human Services Department, Manitowoc County Board of Supervisors, sheriff's department, University of Wisconsin**C**Extension, city of Manitowoc, city of Two Rivers, city of Kiel, all six school districts in Manitowoc County, United Way, the Chamber of Commerce and business leaders, Head Start, Lakeshore Community Action Program and the Family Education and Resource Center, the Mental Health Association, Two Rivers Community Hospital, Holy Family Memorial Medical Center, the Domestic Violence Center, YMCA, local clergy, and citizen members. The final product will be the consensus of all the community stakeholders and service providers involved in services to first-time families in Manitowoc County.

EVALUATION: In designing the evaluation component of Healthy Families Manitowoc County the following guidelines will be followed:

1. The evaluation will include a range of outcome measures.
2. Multiple methods of data collection will be utilized to obtain information on all critical outcome measures.
3. The data collection system will be integrated into the program's ongoing client information system.
4. Client and control assessment will be completed on a predetermined schedule.

5. Process evaluation will be included in the component.

Keywords:

Community Integrated Service System; Families; Parent Education Programs; Family Support Services; Health Care Utilization; Home Visiting Services; Provider Participation; Child Abuse Prevention; Child Neglect; Medicaid Managed Care; Preventive Health Care.

Annotation:

The goal is to develop an integrated, coordinated, collaborative, prevention-based, universal, in-home visitation program for first-time families of Manitowoc County based on the Healthy Families America model. The purpose is to increase the competency of parents, increase the use of preventive health care in targeted families, and reduce the incidence of child abuse and neglect. A project manager will be hired to implement Healthy Families Manitowoc County in collaboration with existing family support and education programs.

Keywords for projects funded by the
Maternal and Child Health Bureau (MCHB)

A list of keywords used to describe MCHB-funded projects follows. Please choose from this list when selecting terms to classify your project.

Please note that this list is constantly under development: new terms are being added and some terms are being deleted. Also, this list is currently being revised so that it will match more closely the approved list of keywords in the MCH Thesaurus. In the meantime, however, this list can be used to help select keywords to describe MCHB-funded projects.

If no term on this list adequately describes a concept which you would like to convey, please select a term which you think is appropriate and include it in your list of keywords.

Access to Health Care
Adolescent Health Programs
Adolescent Nutrition
Adolescent Parents
Adolescent Pregnancy
Adolescent Pregnancy Prevention
Adolescent Risk Behavior Prevention
Adolescents
Adolescents with Disabilities
Advocacy
African Americans
Agricultural Safety
AIDS
AIDS Prevention
Alaska Natives
Alcohol
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Public Health Association
Amniocentesis
Anemia
Ancillary Services
Anticipatory Guidance
Appalachians
Arthritis
Asian Language Materials
Asians
Asthma
Attachment
Attachment Behavior
Attention Deficit Disorder
Audiology
Audiometry
Audiovisual Materials
Baby Bottle Tooth Decay
Battered Women
Behavior Disorders
Behavioral Pediatrics
Bereavement
Bicycle Helmets
Bicycle Safety
Bilingual Services
Biochemical Genetics
Blindness
Blood Pressure Determination
Body Composition
Bonding
Brain Injuries
Breast Pumps
Breastfeeding
Bronchopulmonary Dysplasia
Burns
Cambodians
Caregivers
Case Management
Cerebral Palsy
Chelation Therapy
Child Abuse
Child Abuse Prevention
Child Care
Child Care Centers
Child Care Workers
Child Mortality
Child Neglect
Child Nutrition
Child Sexual Abuse
Childhood Cancer
Children with Special Health Needs
Chronic Illnesses and Disabilities
Cleft Lip
Cleft Palate
Clinical Genetics
Clinics
Cocaine
Collaborative Office Rounds
Communicable Diseases
Communication Disorders
Communication Systems
Community Based Health Education
Community Based Health Services
Community Based Preventive Health
Community Development
Community Health Centers
Community Integrated Service System
Community Participation
Compliance
Comprehensive Primary Care
Computer Linkage
Communication
Computer Systems

Computers
Consortia
Continuing Education
Continuity of Care
Cost Effectiveness
Counseling
County Health Agencies
Craniofacial Abnormalities
Cultural Diversity
Cultural Sensitivity
Curricula
Cystic Fibrosis
Cytogenetics
Data Analysis
Data Collection
Data Systems
Databases
Deafness
Decision Making Skills
Delayed Development
Dental Sealants
Dental Treatment of Children with Disabilities
Depression
Developmental Disabilities
Developmental Evaluation
Developmental Screening
Diagnosis
Diarrhea
Dietitians
Dispute Resolution
Dissemination
Distance Education
Divorce
DNA Analysis
Down Syndrome
Drowning
Early Childhood Development
Early Intervention
Electronic Bulletin Boards
Electronic Mail
Eligibility Determination
Emergency Medical Services for Children
Emergency Medical Technicians
Emergency Room Personnel
Emotional Disorders
Emotional Health
Employers
Enabling Services
Enteral Nutrition
EPSDT
Conferences
Erythrocyte Protoporphyrin
Ethics
Evoked Otoacoustic Emissions
Failure to Thrive
Families
Family Centered Health Care
Family Centered Health Education
Family Characteristics
Family Environment
Family Involvement
Family Medicine
Family Planning
Family Professional Collaboration
Family Relations
Family Support Programs
Family Support Services
Family Violence Prevention
Farm Workers
Fathers
Feeding Disorders
Fetal Alcohol Effects
Fetal Alcohol Syndrome
Financing
Food Preparation in Child Care
Formula
Foster Care
Foster Children
Foster Homes
Foster Parents
Fragile X Syndrome
Genetic Counseling
Genetic Disorders
Genetic Screening
Genetic Services
Genetics Education
Gestational Weight Gain
Glucose Intolerance
Governors
Grief
Gynecologists
Hawaiians
Head Start
Health Care Financing
Health Care Reform
Health Care utilization
Health Education
Health Insurance
Health Maintenance Organizations
Health Professionals
Congenital Abnormalities
Health Promotion
Health Supervision
Healthy Mothers Healthy Babies Coalition
Healthy Start Initiative
Healthy Tomorrows Partnership for Children
Hearing Disorders
Hearing Loss
Hearing Screening
Hearing Tests
Hemoglobinopathies
Hemophilia
Hepatitis B
Hispanics
HIV
Hmong
Home Health Services
Home Visiting for At Risk Families
Home Visiting Programs
Home Visiting Services
Homeless Persons
Hospitals
Hygiene
Hyperactivity
Hypertension
Illnesses in Child Care
Immigrants
Immunization
Incarcerated Women
Incarcerated Youth
Indian Health Service
Indigence
Individualized Family Service Plans
Infant Health Care
Infant Morbidity
Infant Mortality
Infant Mortality Review Programs
Infant Nutrition
Infant Screening
Infant Temperament
Infants
Information Networks
Information Services
Information Sources
Information Systems
Injuries
Injury Prevention
Intensive Care

Interagency Cooperation
Interdisciplinary Teams
Internship and Residency
Intubation
Iron Deficiency Anemia
Iron Supplements
Jews
Juvenile Rheumatoid Arthritis
Laboratories
Lactose Intolerance
Language Barriers
Language Disorders
Laotians
Lead Poisoning
Lead Poisoning Prevention
Lead Poisoning Screening
Leadership Training
Learning Disabilities
Legal Issues
Life Support Care
Literacy
Local Health Agencies
Local MCH Programs
Low Birthweight
Low Income Population
Lower Birthweight
Males
Managed Care
Managed Competition
Marijuana
Marital Conflict
Maternal and Child Health Bureau
Maternal Nutrition
MCH Research
Media Campaigns
Medicaid
Medicaid Managed Care
Medical Genetics
Medical History
Medical Home
Mental Health
Mental Health Services
Mental Retardation
Metabolic Disorders
Mexicans
Micronesians
Migrant Health Centers
Migrants
Minority Groups
Minority Health Professionals
Mobile Health Units
Molecular Genetics
Morbidity
Mortality
Motor Vehicle Crashes
Multiple Births
Myelodysplasia
National Information Resource Centers
National Programs
Native Americans
Needs Assessment
Neonatal Intensive Care
Neonatal Intensive Care Units
Neonatal Mortality
Neonates
Networking
Neurological Disorders
Newborn Screening
Nurse Midwives
Nurses
Nutrition
Obstetricians
Occupational Therapy
One Stop Shopping
Online Databases
Online Systems
Oral Health
Organic Acidemia
Otitis Media
Outreach
P. L. 99-457
Pacific Islanders
Pain
Paraprofessional Education
Parent Education
Parent Education Programs
Parent Networks
Parent Professional Communication
Parent Support Groups
Parent Support Services
Parental Visits
Parenteral Nutrition
Parenting Skills
Parents
Patient Education
Patient Education Materials
Pediatric Advanced Life Support Programs
Pediatric Dentistry
Pediatric Intensive Care Units
Pediatric Nurse Practitioners
Pediatricians
Peer Counseling
Peer Support Programs
Perinatal Health
Phenylketonuria
Physical Disabilities
Physical Therapy
Pneumococcal Infections
Poisons
Preconception Care
Pregnant Adolescents
Pregnant Women
Prematurity
Prenatal Care
Prenatal Diagnosis
Prenatal Screening
Preschool Children
Preterm Birth
Preventive Health Care
Preventive Health Care Education
Primary Care
Professional Education in Adolescent Health
Professional Education in Behavioral Pediatrics
Professional Education in Breastfeeding
Professional Education in Chronic Illnesses and Disabilities
Professional Education in Communication Disorders
Professional Education in CSHN
Professional Education in Cultural Sensitivity
Professional Education in Dentistry
Professional Education in Developmental Disabilities
Professional Education in EMSC
Professional Education in Family Medicine
Professional Education in Genetics
Professional Education in Lead Poisoning
Professional Education in MCH
Professional Education in Metabolic Disorders

Professional Education in Nurse Midwifery
Professional Education in Nursing
Professional Education in Nutrition
Professional Education in Pulmonary Disease
Professional Education in Social Work
Professional Education in Violence Prevention
Provider Participation
Psychological Evaluation
Psychological Problems
Psychosocial Services
Public Health Academic Programs
Public Health Education
Public Health Nurses
Public Policy
Public Private Partnership
Puerto Ricans
Pulmonary Disease
Quality Assurance
Recombinant DNA Technology
Referrals
Regional Programs
Regionalized Care
Regulatory Disorders
Rehabilitation
Reimbursement
Repeat pregnancy prevention
Research
Residential Care
Respiratory Illnesses
Retinitis Pigmentosa
Rheumatic Diseases
RNA Analysis
Robert Wood Johnson Foundation
Runaways
Rural Population
Russian Jews
Safety in Child Care
Safety Seats
Sanitation in Child Care
School Age Children
School Dropouts
School Health Programs
School Health Services
School Nurses
Professional Education in Occupational Therapy
Professional Education in Physical Therapy
Professional Education in Schools
Screening
Seat Belts
Self Esteem
Sensory Impairments
Service Coordination
Sex Roles
Sexual Behavior
Sexuality Education
Sexually Transmitted Diseases
Shaken Infant Syndrome
Siblings
Sickle Cell Disease
Sleep Disorders
Smoking During Pregnancy
Social Work
Southeast Asians
Spanish Language Materials
Special Education Programs
Specialized Care
Specialized Child Care Services
Speech Disorders
Speech Pathology
Spina Bifida
Spouse Abuse
Standards of Care
State Health Agencies
State Health Officials
State Legislation
State Programs
State Staff Development
State Systems Development Initiative
Stress
Substance Abuse
Substance Abuse Prevention
Substance Abuse Treatment
Substance Abusing Mothers
Substance Abusing Pregnant Women
Substance Exposed Children
Substance Exposed Infants
Sudden Infant Death Syndrome
Suicide
Supplemental Security Income Program
Primary Care
Professional Education in Psychological Evaluation
Support Groups
Support Services
Surveys
Tay Sachs Disease
Technology Dependence
Teleconferences
Television
Teratogens
Terminally Ill Children
Tertiary Care Centers
Thalassemias
Third Party Payers
Title V Programs
Toddlers
Training
Transportation
Trauma
Tuberculosis
Twins
Uninsured
Unintentional Injuries
University Affiliated Programs
Urban Population
Urinary Tract Infections
Usher Syndrome
Vietnamese
Violence
Violence Prevention
Vision Screening
Vocational Training
Waiver 1115
Well Baby Care
Well Child Care
WIC
Youth in Transition

Enclosure D

GLOSSARY

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors.

Care Coordination Services for CSHCN - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Cultural Competence - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multi cultural staff in the policy development, administration and provision of those services. Cultural competence is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

At a system, organizational or program level, cultural competence requires a comprehensive and coordinated plan. This may include consideration of the role of cultural competence as it relates to: (1) policy making; (2) infra-structure building; (3) program administration and evaluation; (4) the delivery of services and enabling supports; and (5) the individual - both those delivering and receiving such services and enabling supports. Such efforts often require the re-examination of: mission statements; policies and procedures; administrative practices; approaches for staff recruitment, hiring and retention; professional development and in-service training; the provision of translation and interpretation services;

family/professional/community partnerships; health care practices and interventions including addressing racial/ethnic health disparities and access issues; health education and promotion practices/materials; and protocols for assessing community and state strengths and needs.

At the individual level, cultural competence requires an understanding of one=s own culture and world view and how they are reflected in one=s attitudes and behavior. Cultural competence necessitates that one acquires values, principles, areas of knowledge, attributes and skills in order to work in cross cultural situations in a sensitive and effective manner.

Cultural competence mandates that organizations, programs and individuals must have the ability to:

1) value diversity and similarities among all peoples;
2) understand and effectively respond to cultural differences;
3) engage in cultural self-assessment at the individual and organizational levels;
4) make adaptations to the delivery of services and enabling supports; and
5) institutionalize cultural knowledge.

Direct Health Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians.. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

AEPSDT@ - definition to be determined

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - definition to be determined the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Belau.

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available; and,
3) What is missing

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives CAN BE related to health STATUS, PROGRAM AND/OR SYSTEMS.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal.

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame.
Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual=s or family=s health care services.

Service System - a system of services for CHILDREN AND children with special health needs should be:

1. **Collaborative** - with collaboration between the State Title V program and
   (1) other relevant **State** health and non-health agencies, provider and consumer groups to develop an organizational infrastructure to facilitate systems development
   (2) public-private organizations and community leaders (formal and informal) linking health related and other **community**-based services,
   (3) **families** of cultures representative of the population to be served to participate in the system development process.

2. **Family Centered** - the process of ensuring that the ways in which services are organized and delivered meet the emotional, social and developmental needs of children and that their families are integrated into all aspects of the health care plan. In family-centered care, the key to designing and implementing successful services is to base them on needs as identified by families rather than only on needs perceived by professionals.

3. **Community Based** - where quality services are provided in or near the home community as possible. The area encompassed by a Acommunity@ would depend upon factors including population density and characteristics, apolitical subdivisions, existing arrangements for service

provision and the availability of resources.

4. **Culturally Competent** - a set of congruent behaviors, attitudes, and policies that come together on a continuum in a system, agency, or individual that enable that system, agency, or individual to function effectively in trans-cultural interactions. It refers to the ability to honor and respect beliefs, interpersonal styles, attitudes, and behaviors of families who are clients as well as the multi cultural staff who provide services. Systems and agencies need to incorporate these values at the levels of policy, administration, practice, and advocacy.

5. **Coordinated/Integrated** - having a broad array of services coordinated to assure timeliness, appropriateness, continuity and completeness of care and a mechanism to finance them.

6. **Comprehensive** - where preventive, primary, secondary and tertiary care can be accessed to address physical and mental health, nutrition, oral health, health promotion and education, ancillary therapies and emergency medical services. Other services that should be available either through one stop shopping or family friendly referrals are social, vocational, early intervention, educational, recreational and family support services.

7. **Universal** - the Title V system should be concerned with all infants, children and adolescents with or at risk for special health needs as a component of the overall health system for all pregnant women, infants, children and adolescents and their families whether served by private providers or public programs.

8. **Accessible** - services are located and provided so that consumers have physical access (convenient and handicapped accessible for families; temporal access (wide choice of service hours), and; financial access (financial mechanisms to bring needed services within the reach of all)

9. **Developmentally Oriented** - the different needs that children, adolescents and their families have at different stages of development and knowledge are taken into account.

10. **Accountable** - a feedback/modification mechanism is in place that provides information concerning performance, quality assurances and utilization of services.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public

health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

BIOGRAPHICAL SKETCH **Attachment B**

Give the following information for all professional personnel contributing to the project, beginning with the Program Director. Photocopy this page for each person.
(DO NOT EXCEED 2 PAGES ON ANY INDIVIDUAL)

NAME *(Last, first, middle initial)*

EDUCATION *(Begin with baccalaureate or other initial professional education and include postdoctoral training)*

INSTITUTION AND LOCATION	DEGREE	YEAR CONFERRED	FIELD OF STUDY

HONORS

MAJOR RESEARCH - PROFESSIONAL INTEREST

CURRENT RESEARCH AND OTHER GRANT SUPPORT

RESEARCH AND PROFESSIONAL EXPERIENCE: List in reverse chronological order previous employment and experience. List in reverse chronological order all publications, or most recent presentation if the 2 page limit on the sketch presents a problem.

CONTINUATION PAGE FOR BIOGRAPHICAL SKETCH

NAME *(Last, first, middle initial)*

SUPPLEMENTAL TO SECTION F OF FORM 424A **Attachment C**

KEY PERSONNEL

NAME AND POSITION TITLE	Annual SALARY	No. MONTHS BUDGET	% TIME	Total $ AMOUNT REQUESTED
	(1)	(2)	(3)	(4)
	$		%	

FRINGE BENEFIT (Rate___) TOTAL $

ERSONNEL ALLOCATION CHART

Project Director: _____

_____ to _____ Project Year: _____ State: _____

(1,2,3,4 or 5)

Approaches	Staff by Title and Consultants in Person Days					